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Critical Access Hospitals: Preparing and Submitting Compliant Inpatient Claims to Medicare

5/22/2025

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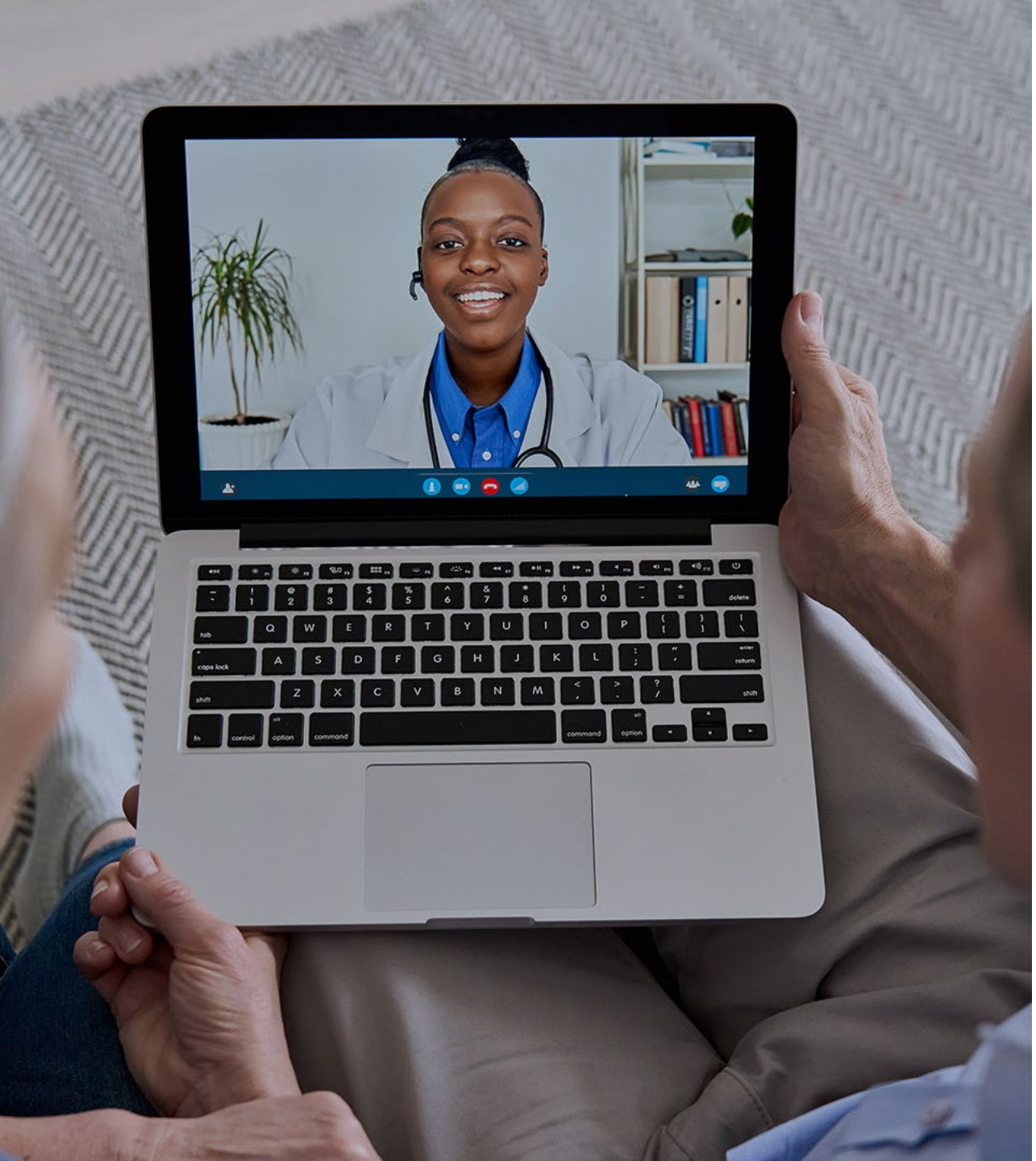

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Objective

Assist CAHs in understanding how to prepare and submit compliant claims to Medicare for inpatient hospital services

Today's Presenters

- Provider Outreach and Education Consultants
  - Michael Dorris
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

CAH and IP Hospital Payment

CAH

- Designation given by CMS to eligible rural hospitals
  - Separate provider type with your own CoP and payment method
  - CoP in 42 CFR 485, Subpart F
- CAH eligibility
  - Currently-participating Medicare hospitals
  - Hospitals that ceased operations on/after 11/29/1989
  - Health clinics or centers (as defined by the state) that previously operated as hospital before being downsized
    - S1820 of SSA established Medicare Rural Hospital Flexibility Programs (MRHFPs) that allow states to designate certain facilities as CAHs

CAH Designation Criteria

- In state with MRHFP and designated by state as CAH
- In rural area or area treated as rural
- More than 35 miles from nearest hospital or CAH **or** more than 15 miles in areas with mountainous terrain or only secondary roads
  - Or < 1/1/2006, certified as CAH per state designation of "necessary provider"
- No more than 25 beds that can be used for IP hospital or swing bed
- Annual ALOS of 96 hours or less per patient for acute IP care
- Demonstrate compliance with CAH CoP
- Furnish 24-hour emergency care services seven days week

CAHs – Additional IP Services

- CAHs may
  - Receive swing bed approval to provide post-hospital SNF-level care in IP beds
  - Contract with hospice to provide Medicare hospice hospital benefit
  - Operate psychiatric and/or rehabilitation DPUs of up to ten beds each
    - In addition to 25 IP CAH beds
    - Must comply with hospital and DPU CoPs

PTANs and Payment for IP Hospital Services

- CAH PTAN range = XX1300 - XX1399
  - IP payment = 101% of reasonable cost for facility charges
    - Charges x interim rate – deductible and/or coinsurance
    - Fully cost reimbursed at cost report settlement
- Psychiatric DPU PTAN range = XXMXXX
  - Payment = IPF PPS
- Rehabilitation DPU PTAN range = XXRXXX
  - Payment = IRF PPS

Preadmission Services Window Policy Does Not Apply

- CAHs not subject payment window policy
  - If CAH renders OP services prior to and/or on day of IP CAH admission
    - May submit OP services separately and not report on IP claim
      - Note: If CAH is wholly-owned or wholly-operated by admitting entity, admitting entity may need to include OP CAH services on its IP claim

Coverage Requirements for IP CAH Stays

Coverage Conditions

- CAH must
  - Have provider agreement with Medicare to be participating hospital
  - Meet CoP for CAHs
- Beneficiary must
  - Be enrolled in Medicare Part A
  - Have Medicare IP hospital benefit days available in benefit period
  - Receive medically R&N care that can only be provided in IP hospital
- Physician must
  - Formally admit beneficiary as an IP for treatment of illness or injury

Coverage Conditions (continued 2)

- Physician must (continued)
  - Order admission and certify they expect patient to be discharged or transferred to a hospital within 96 hours of CAH IP admission per 42 CFR 424.15 and 42 CFR 485.638(a)(4)(iii)
    - 96-hour certification clock starts when physician admits patient via written order in medical record
    - Beneficiary may remain in CAH for longer period
    - CAH designation remains if it stays within 96-hour annual ALOS requirement
    - 20 or more IP day cases must meet additional certification requirements per 42 CFR, Section 424.13
  - Complete/sign certification and document in medical record no later than one day before submitting IP claim

Two-Midnight Rule

- Part A services performed in IP setting
  - Generally appropriate for admission and payment when physician admits patient based on expectation stay will cross at least two midnights
- Physician must
  - Formally admit beneficiary as IP via IP order per 42 CFR. Section 412.3
  - Expect patient will remain at least overnight even if discharged or transferred and does not use bed overnight
- References:
  - CMS Fact Sheet About Two-Midnight Rule
  - CR10080, Clarifying Medical Review of Hospital Claims for Part A Payment
  - CMS-1599-F

General IP Hospital Information

Tip – Verify Beneficiary Has Medicare Part A

- CAH staff must
  - Collect insurance information and cards from beneficiary
  - Determine if beneficiary has
    - FFS Medicare or MAO plan
      - Medicare's records (FISS DDE/CWF, HETS, and/or NGSConnex)
    - Coverage primary to Medicare
      - MSP screening process
      - Determine proper insurance order per MSP Provisions

IP Benefit Days Under Medicare Part A per Benefit Period

- Per benefit period, beneficiary receives
  - 100 IP SNF/swing bed benefit days
    - 20 full days and 80 coinsurance days (renewable)
  - Up to 150 IP hospital benefit days
    - 90 regular days (renewable)
      - First 60 days = full days; deductible applies
      - Next 30 days = coinsurance days; daily coinsurance applies
    - 60 LTR days (not renewable)
      - Daily coinsurance applies

IP Hospital LTR Days

- Beneficiary
  - Can elect not to use LTR days
  - May be responsible for cost of stay past regular benefit days
- Provider
  - Must inform beneficiary of right not to use LTR days
- Reference:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 5

Medicare Beneficiary Responsibility

- Beneficiary's IP hospital liability limited to:
  - Deductible
    - 2025 = $1,676
  - Regular day coinsurance (days 61-90)
    - 2025 = $419 per day
  - LTR day coinsurance (days 91-150)
    - 2025 = $838 per day
  - Services not medically R&N (beneficiary liable services; must notify beneficiary)
  - Statutorily excluded services

Medicare Benefit Period

- Tracks beneficiary's use of IP benefit days
  - Specific number of IP benefit days available for use in benefit period
    - IP hospital and IP SNF/swing bed benefit days used separately but linked to same benefit period
  - Benefit period begins/ends
    - Begins when beneficiary admitted as IP to qualified hospital or SNF/swing bed after Part A entitlement date
    - Ends 60 consecutive days from date of beneficiary's last IP discharge
      - Beneficiary not IP in hospital or receiving IP skilled care in SNF/swing bed for 60 days in a row
- Reference:
  - CMS IOM Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual,* Chapter 3

Benefit Period Facts

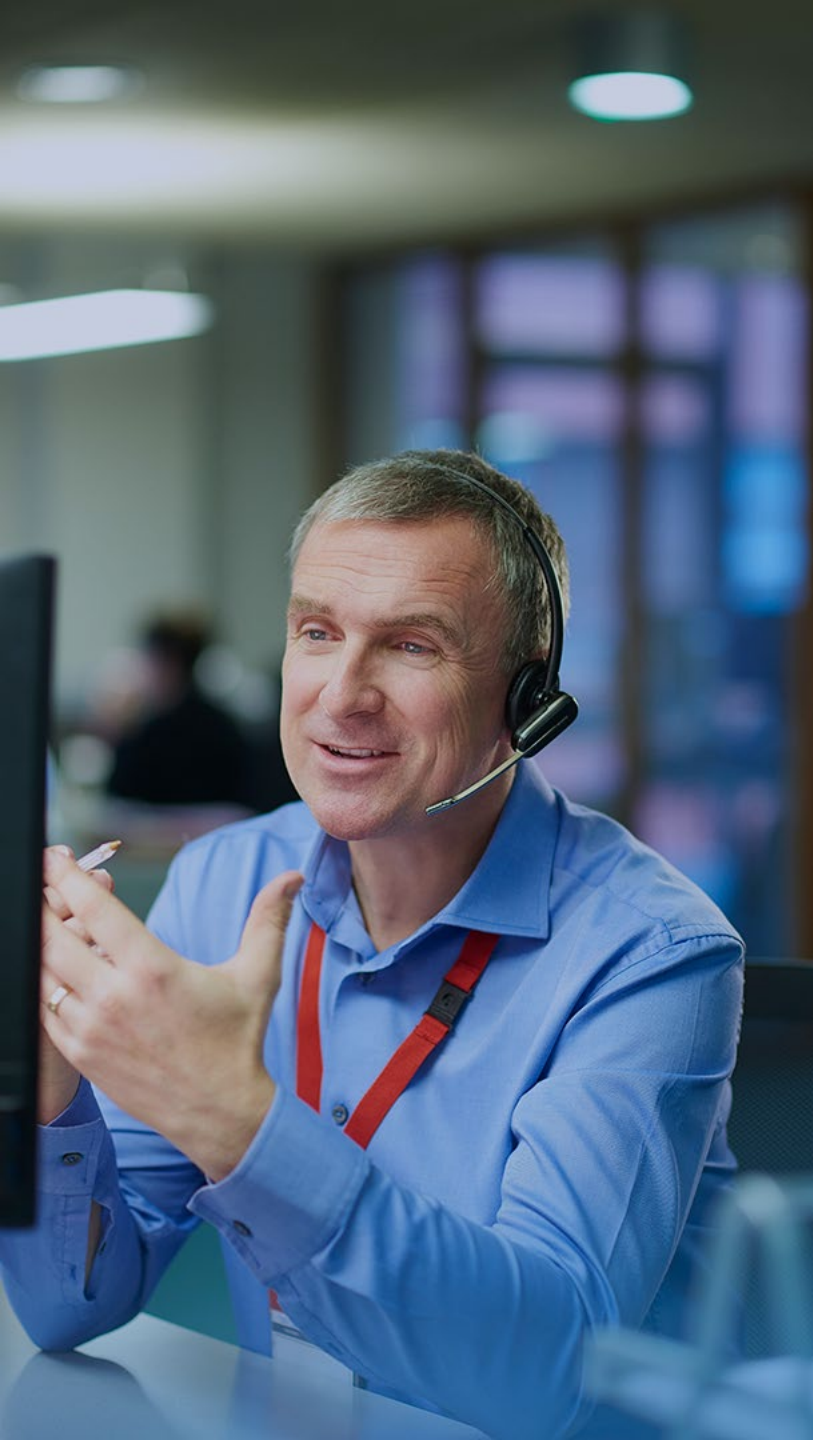
- Also known as spell of illness
- Doesn't begin when beneficiary has a new illness/injury
- Doesn't end if beneficiary admitted as IP to hospital or SNF/Swing bed prior to 60th consecutive day from last IP discharge
- Beneficiary continues to use any remaining IP benefit days available
- Isn't bound by calendar year
  - Can last for years if beneficiary not facility-free for 60 consecutive days or does not have 60 consecutive-day break in skilled care from SNF/Swing bed
  - Facility-free = also known as break in spell of illness
    - To count 60 consecutive-day period, begin with day of IP discharge

Benefit Period Examples

- Who gets a new benefit period?
  - I's 5/22/2025 and you work at ABC CAH
  - Three beneficiaries waiting to be admitted
  - Determine if eligible for new benefit period
  - Review recent IP summaries for each beneficiary on next slide

Does Beneficiary Get a New Benefit Period When Admitted on 5/22/2025?

- Mrs. A
  - IP hospital stay 1/3/2025 – 1/10/2025
  - Not IP in any other hospital or SNF/Swing bed since 1/10/2025
    - Yes; more than 60 days passed from 1/10/2025 to 5/22/2025
- Mr. B
  - IP CAH stay 4/14/2025 – 4/23/2025
  - Not IP in any other hospital or SNF/Swing bed since 4/23/2025
    - No; less than 60 days passed from 4/23/2025 to 5/22/2025
- Mrs. C
  - IP hospital stay 12/28/2024 – 1/2/2025
  - Transferred to SNF on 1/2/2025 (covered); discharged home on 3/26/2025
  - Not in any other hospital or SNF/Swing bed since 3/26/2025
    - No; less than 60 days passed from 3/26/2025 to 5/22/2025



Tip – Verify Benefit Period and IP Hospital Benefit Days Available

- Determine if beneficiary was IP in hospital or SNF/Swing bed (skilled LOC) within past 60 days
  - If yes, he/she in a current benefit period
    - Determine IP hospital benefit days used and remaining
    - Obtain name/address of provider(s)
  - If no, he/she not in current benefit period
    - This IP admission starts new benefit period

IP Hospital Benefits Exhausted

- IP hospital benefit days exhaust when
  - All 90 regular days used in benefit period
  - No LTR days remaining

Covered IP Hospital Services Include But Are Not Limited to...

- Semiprivate room
- All meals including special diets
- Regular nursing services
- Intensive care/coronary care units
- Drugs/medications
- Operating/recovery room costs
- Laboratory, x-ray, and radiology services
- Blood transfusions
- Rehabilitation services
- Speech, physical and occupational therapy
- Other hospital services

General Exclusions from Medicare

- Include but are not limited to
  - Services not R&N
  - Custodial care
  - Certain dental services
  - Routine foot care
  - Cosmetic surgery
- References:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
  - MLN® Booklet: *Items and Services Not Covered Under Medicare*

IP Hospital Discharge Planning

- Hospitals must
  - Have discharge planning process for all patients
  - Include discharge planning evaluation in patient's medical records
    - Must include evaluation of patient needing post-hospital services and availability of services
  - Discuss results of evaluation with patient or individual acting on his/her behalf

IP Beneficiary Notices

- Provide appropriate HINN to beneficiary if you determine items/services not covered
  - Provide
    - Prior to admission
    - At admission
    - At any point during IP stay
  - Not covered
    - Not reasonable and medically necessary
    - Not delivered in most appropriate setting or
    - Custodial in nature
- Beneficiary Notices Initiative (BNI)

IP Beneficiary Notices (continued 1)

- HINNs
  - HINN 1: Preadmission/Admission HINN – used when stay entirely noncovered
  - HINN 10: Notice of Hospital Requested Review (HRR) – used when hospital requests Beneficiary and Family Centered Care (BFCC)-QIO review of a discharge decision without physician concurrence
  - HINN 11: Noncovered Service(s) during Covered Stay – used when noncovered services during otherwise covered stay
  - HINN 12: Noncovered Continued Stay – used in association with Hospital Discharge Appeal Notice to inform beneficiary of potential financial liability for noncovered continued IP stay

IP Beneficiary Notices (continued 2)

- FFS & MA IM – Additional information on Important Message (IM) from Medicare and Detailed Notice of Discharge (DND)
  - IM
    - Beneficiary notice issued within two days of IP admission to explain rights as a patient
    - Follow-up copy provided up to two days, and no later than four hours, before IP discharge
  - DND
    - Issued to IP who requests expedited review of discharge to explain specific reason for discharge

IP Beneficiary Notices (continued 3)

- Medicare Change of Status Notice (CMS-10868)
  - Effective 10/11/2024 and implemented 2/15/2025
  - Hospitals providing IP LOC must issue to beneficiaries formally admitted as IP but reclassified to OP receiving observation services
    - Deliver to those eligible for expedited determination process while still IP to notify them of their right to appeal reclassification with BFCC-QIO
      - Deliver as soon as possible, but no later than four hours prior to discharge
  - Reference:
    - MLN Matters® *MM13846: Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services)*

IP Hospital Claims Subject to Review

- Potential review entities include:
  - Targeted Probe and Educate
  - Comprehensive Error Rate Testing (CERT)
  - Quality Improvement Organizations
  - Medicare Fee for Service Recovery Audit Program
  - Supplemental Medical Review Contractor

Preparing Claims for Submission to Medicare

Billing Instructions

- Complete claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Section 30

Claim Resources

- Claim form
  - UB-04/CMS-1450, 837I claim or claim entry via FISS DDE
  - MLN® Booklet: *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- FLs
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
    - FL 1 to FL 81 names and descriptions but no codes
    - FLs may be required or situational
- Codes
  - NUBC members access billing codes from *NUBC's UB-04 Data Specifications Manual*

Prior to Submitting Claims to Medicare

- Check with internal departments to ensure all services reported on claim
- Verify all required data elements entered accurately and completely
- Check if claim already submitted
- Consider our one-year timely filing requirement
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

Submitting Claims to Medicare

- UB-04/CMS-1450 hardcopy claim form
  - Must have approved ASCA waiver
  - ASCA Requirements for Paper Claim Submission
- Via FISS DDE or through clearinghouse
- Using 837I electronic claim form
- Get started with EDI
  - EDI and How it Works
  - *EDI enrollment Process User Guide*

Claims S/LOC in FISS

- When claim submitted for processing, it receives S/LOC
  - Basic S/LOCs include:
    - P B9997 – Claim processed
    - S XXXXX – Claim suspended
    - R B9997 – Claim rejected
    - T B9997 – Claim RTP
    - D B9997 – Claim denied

Claim Status and Provider Action

- If claim RTP (S/LOC = T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
    - Select F9 to resubmit claim
- If claim rejected (S/LOC = R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim denied (S/LOC = D B9997)
  - Determine if appeal needed
  - Documentation must support services rendered

FL Review

Assumptions for Presentation

- You determined Medicare primary payer
  - No other primary payers involved
    - Not reviewing MSP-related claim FLs or codes
- You understand how to code required claim information for
  - Provider identification
  - Patient identification

Claim FLs for Provider Identification

- FL 1 = Billing provider name, address, telephone number
- FL 5 = Federal tax number
- FL 56 = Billing provider NPI
- FL 76 = Attending provider name and identifiers
- FL 77 = Operating provider name and identifiers
- FLs 78 and 79 = Other provider name and identifiers

Claim FLs for Patient Identification

- FL 3a = Patient control number
- FL 3b = Medical/health record number (situational)
- FL 8 = Patient's name and identifier
- FL 9 = Patient's address
- FL 10 = Patient's birth date
- FL 11 = Patient's sex
- FL 50a = Payer (Enter Medicare if Medicare primary)
- FL 58a = Insured's name (Enter beneficiary if Medicare primary)
- FL 59a = Patient's relationship to insured (Enter 18 if Medicare primary)
- FL 60a = Insured's unique ID (certificate/social security number/**MBI**)

Other Claim FLs

- FL 4 = TOB
- FL 6 = Statement covers period (from and through dates)
- FL 12 = Date of admission
- FL 14 = Priority (type) of admission
- FL 15 = Point of origin for admission
- FL 17 = PSC as of statement covers period through date (FL 6)
- FLs 18-28 = CCs
- FLs 31-34 = OCs and dates
- FLs 35-36 = OSCs with from/through dates
- FLs 39-41 = VCs and amounts
- FL 42 = Revenue code

Other Claim FLs (continued)

- FL 44 = HCPCS/Rates/HIPPS Rate codes (accommodation rate)
- FL 46 = Unit(s) of service
- FL 47 = Total charges (not needed for electronic billing)
- FL 48 = Noncovered charges
- FL 64 = DCN
- FL 67 = Principal diagnosis code
- FLs 67 A-Q = Other diagnosis codes
- FL 69 = Admitting diagnosis code
- FL 74 = Principal procedure code and date
- FLs 74 A-E = Other procedure codes and dates
- FL 80 = Remarks

FL 4 – TOB

- Required
  - Four-digit alphanumeric code
    - First digit = zero (ignored)
    - Second digit = type of facility
    - Third digit = type of care
    - Fourth digit = sequence of bill in episode of care; frequency code
- IP claim submissions = one claim per stay
  - Submit through final discharge/death even if IP hospital benefit days exhaust or care becomes noncovered

TOBs for IP Claims

- TOB 11X – CAH IP Part A claims
  - 111 = Admit to discharge claim
  - 112 = Interim claim
  - 114 = Final interim claim
  - 117 = Adjustment claim
  - 118 = Cancel claim
    - For adjustments and cancels, enter original claim's DCN in FL 64
  - 110 = No-payment claim
- TOB 12X – CAH IP Part B claim (IP ancillary)

TOB 111

- IP claim from admission to final discharge/death
  - Admission date = actual admission date
  - Statement from date = admission date
    - If admitted prior to Part A entitlement date, report Part A entitlement date
      - Inpatient Admission Prior to Medicare Entitlement Job Aid
  - Statement through date = discharge/death date
    - Always report PSC that accurately represents beneficiary's status as of this date
- Submit at final discharge/death

TOBs 112 and 114

- Stay begins before but ends after FY end date
  - Split bill using interim claims instead of TOB 111
  - TOB 112 up to FY end date
    - PSC = 30
  - TOB 114 from FY beginning date through discharge/transfer or death
    - Appropriate PSC

TOB 117 for Adjustment Claims and TOB 118 for Cancel Claims

- IP adjustment claim
  - Submit to change or correct original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires one claim change reason code (adjustment reason) D0 – E0
- IP cancel claim
  - Submit to cancel original claim
  - Requires one claim change reason code (cancel reason) D5 or D7
- FISS Claim Change/Condition Reason Codes

TOB 110 for IP No-Payment Claims

- Submit for all IP stays when no payment expected from us
  - Except when beneficiary enrolled in Part B only
- Submit TOB 110 if beneficiary's
  - Medicare IP hospital benefit days exhausted at admission
  - Admission denied (not medically R&N for entire stay)
  - Stay denied per hospital self-audit
  - Stay denied per MAC or medical review contractor

TOB 12X for IP Ancillary Claims

- IP ancillary claim for services to inpatients submitted under Part B when Part A can't pay for IP stay
  - Report revenue codes, units, charges, LIDOS (FL 45), CPT/HCPCS codes
  - Billable services depend on reason Part A can't pay for IP stay
    - Beneficiary has no Part A or BE
      - Bill services per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2
      - Do not bill services in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2
    - If IP stay denied not medically R&N
      - Bill services per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1
      - Do not bill services in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.1

Did You Know

- There are several services which, when provided to a hospital IP, are covered under Part B, even though the patient has Part A coverage for the hospital stay.
  - Review CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 250
  - Example: Certain vaccines/administration
    - Influenza, PPV, and hepatitis B
    - For DOS, use discharge date or BE date

FL 6 – Statement Covers Period (Required)

- Beginning and ending dates of period on bill (MMDDYY)
  - From date = beginning date of claim
    - IP admission date unless admitted prior to Part A entitlement date (in which case report Part A entitlement date)
  - Through date = ending of claim
    - Date of discharge/transfer or death)

FL 12 – Admission/Start of Care Date (Required)

- Date beneficiary formally admitted as an IP for IP care
- Format: MMDDYY

FL 14 – Priority (Type) of Admission (Required)

- Options:
  - 1 = Emergency
  - 2 = Urgent
  - 3 = Elective
  - 4 = Newborn
  - 5 = Trauma center
  - 9 = Not available

FL 15 – Point of Origin for Admission (Required)

- Code indicating source of referral for admission:
  - 1 = Non-health care facility
  - 2 = Clinic or physician's office
  - 4 = Transfer from hospital (different facility)
  - 5 = Transfer from SNF, assisted living, ICF or other nursing facility
  - 6 = Transfer from another health care facility
  - 8 = Court/law enforcement
  - 9 = Information not available
  - D = Transfer from distinct unit of hospital to another of same hospital resulting in separate claim to payer
  - E = Transfer from ASC
  - F = Transfer from a hospice facility
  - G = Transfer from a designated disaster alternate care site

FL 17 – Patient Discharge Status (Required; Known as PSC)

- As of “through” date of billing period (FL 6)
  - Two-digit codes
  - Select carefully and report accurately
  - What do your internal records indicate?
  - What is receiving facility’s provider type?
  - If we cancel/RTP claim (reason code C7272), resubmit with correct PSC
- PSC options:
  - 07 = Left against medical advice or discontinued care
  - 09 = Admitted as an IP to this hospital
  - 20 = Patient expired
  - 30 = Still a patient

PSC Options

- Discharged/transferred to:
  - 01 = Home or self-care
  - 02 = Short-term general hospital as IP
  - 03 = SNF for covered skilled care
  - 04 = ICF
  - 05 = Cancer or children's hospital
  - 06 = Home for covered home health care
  - 21 = Court/law enforcement
  - 43 = Federal health care facility (VA hospital)
- Discharged/transferred to:
  - 50 = Hospice (home)
  - 51 = Hospice (medical facility)
  - 61 = Swing bed
  - 62 = IRF
  - 63 = LTCH
  - 64 = Nursing facility (Medicaid)
  - 65 = IPF
  - 66 = CAH
  - 70 = Another type of health care institution

FLs 18 to 28 – CCs (Situational)

- Two-digit code describing certain conditions or events
  - Common IP CCs (not an all-inclusive list):
    - 04 = MAO plan enrollee
    - 07 = Hospice patient services not related to terminal illness
    - 40 = Same-day transfer
    - 67 = Beneficiary elects not to use LTR days
    - 68 = Beneficiary elects to use LTR days (charges < LTR coinsurance)
    - 69 = Billing for IME, DGME or N&AH
    - C1 - C7 = QIO approval indicators
    - D0 - E0 = Claim change reason codes for adjustments and cancels
      - FISS Claim Change/Condition Reason Codes

MAO Plan Enrollees

- If patient MAO plan enrollee for entire IP stay, bill MAO plan
- If patient MAO plan enrollee for portion of IP stay, split bill:
  - Bill FFS Medicare for portion of IP stay covered by FFS Medicare
  - Bill MAO plan for portion of IP stay covered by MAO plan
- In addition to billing MAO plan, bill us to receive EHR payments
  - TOB (not 110) with covered charges
  - CC 04 (MAO plan enrollee)
  - CC 69 only if CAH is teaching hospital
  - All other required claim elements
  - Medicare primary claim coding
  - Report MBI; not MAO plan information
  - One-year timely filing applies

FLs 31 to 34 – OCs and Dates (Situational)

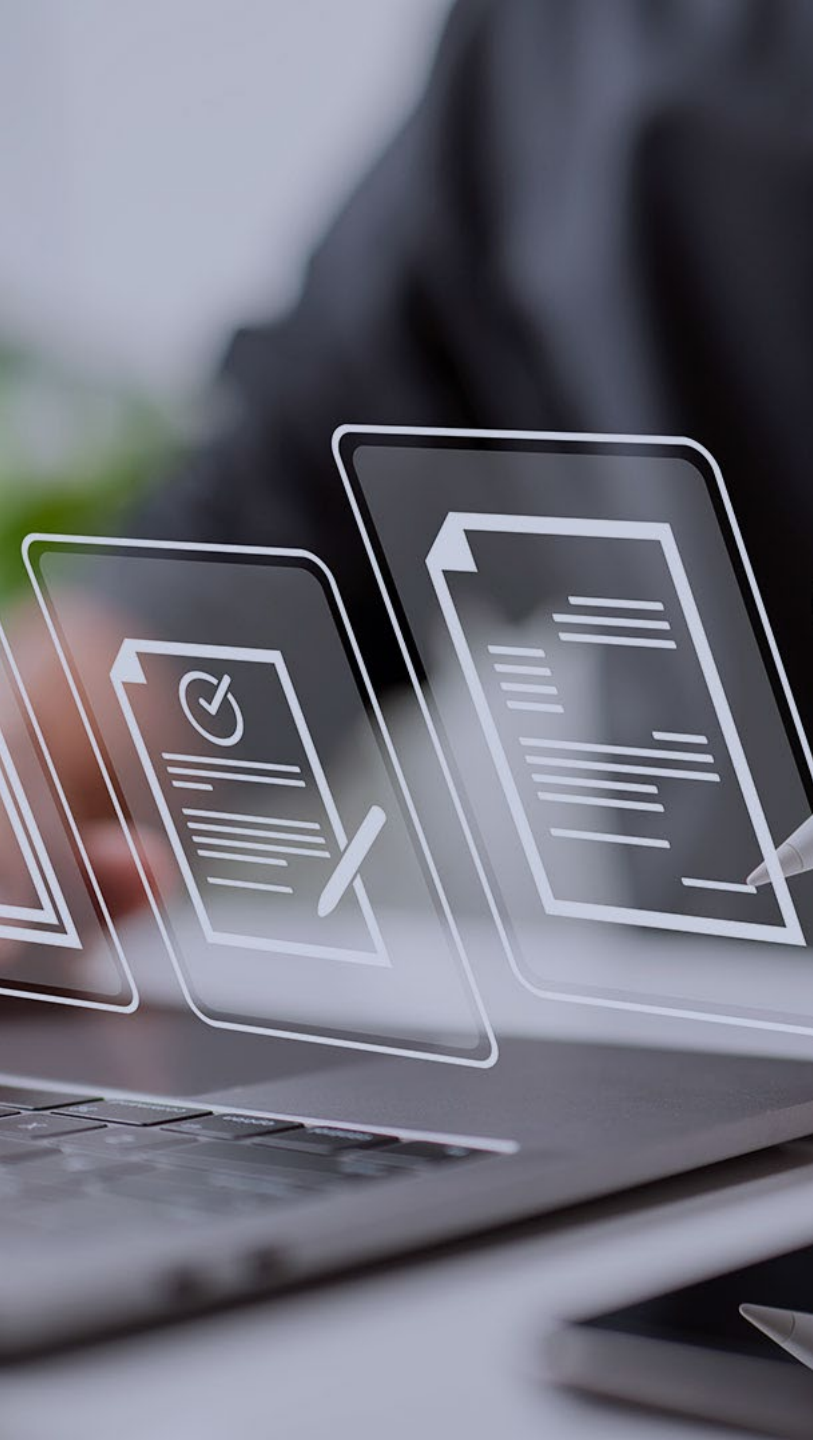
- Two-digit code for certain events or occurrences and date in MMDDYY format
  - Common IP OCs (not an all-inclusive list):
    - 26 and date SNF bed became available to IP who required SNF LOC
    - 31 and date of written notice to patient – not at covered LOC
    - 32 and date of written notice to patient – service/treatment not covered
    - 55 and date of death
    - A3 and benefits exhaust date

FLs 35 To 36 – OSCs and Dates (Situational)

- Two-digit code for certain events related to services
  - Associated from and through dates in MMDDYY format
    - Common IP OSCs (not an all-inclusive list):
      - 74 = LOA
      - 75 = Period of SNF LOC during IP hospital stay
      - 76 = Period of noncovered care for which beneficiary liable
      - 77 = Period of noncovered care for which provider liable, other than lack of medical necessity or custodial care (utilization)
      - M0 = QIO/UR stay dates
      - M1 = Period of noncovered care for which provider liable, lack of medical necessity or custodial care (no utilization)

FLs 39 To 41 – VCs and Dollar or Unit Amounts (Situational)

- Two-digit code and dollar or unit amount (number)
  - Up to nine numeric digits (0000000.00)
  - Four lines of data, line A through line D
    - Use FLs 39A - 41A before 39B - 41B
  - Common VCs (not all-inclusive list):
    - 08 = LTR amount first CY in billing period (LTR days X LTR coinsurance amount)
    - 09 = coinsurance amount first CY in billing period (coinsurance days X coinsurance amount)
    - 10 = LTR amount second CY in billing period (LTR days X LTR coinsurance amount)
    - 11 = coinsurance amount second CY in billing period (coinsurance days X coinsurance amount)
    - 31 = patient liability amount; noncovered LOC
    - 80 = covered days
    - 81 = noncovered days
    - 82 = coinsurance days
    - 83 = LTR days



FL 42 – Revenue Codes (Required)

- Revenue codes for services provided to patient directly or under arrangement:
  - Accommodations (010X–012X)
  - Ancillary charges (022X–099X)
  - Alternative therapy services (210X)
  - Add total charges line (0001)
- Tip: We RTP claims with reason code 32242 if submitted with noncovered revenue codes

Services Furnished to Hospital Inpatients

- All items and nonphysician services furnished to inpatients must be
  - Furnished directly by your hospital or
  - Billed through your hospital under arrangement
    - Including transportation to/from another facility to receive services not available
- Under arrangement
  - Send beneficiary to another facility for services
    - Usually OP services, beneficiary returns on same day
  - Reimburse that facility for OP services
    - Other facility submits claim to you; not to Medicare
  - Report arranged service and cost on IP claim
    - Revenue code for arranged service only; not 0540
    - Cost for arranged service and transportation

CRNA Services

- Qualifying CAHs
  - Eligible for pass-through payments for authorized CRNA services
    - Allows separate payment for services over and above usual calculated amount
    - Available to CRNAs in IP and OP settings
  - May include CRNA professional fees on IP claims
    - If CRNA not included in Method II OP reimbursement
      - Bill IP CRNA professional charges with revenue code 0964
      - Report separately from anesthesia and supplies
      - Bill IP CRNA technical services with revenue code 037X
  - If CRNA included in Method II reimbursement
    - Bill IP CRNA professional charges on CMS-1500 claim form to Part B MAC

FL 44 – HCPCS/Rates/HIPPS Rate Codes (Required)

- Accommodations rate for each accommodation revenue code on claim
  - When reporting revenue code 0636, report valid HCPCS code
    - Drugs requiring detailed coding, including hemophilia clotting factors

FL 46 – Units of Service (Required)

- UOS for each revenue code on claim
- Quantifies services provided
  - For accommodations, UOS must = number of days
    - If not, we RTP claim with reason code 15202
  - When HCPCS codes required
    - Units = number of times procedure/service performed

FLs 47 and 48 (Required)

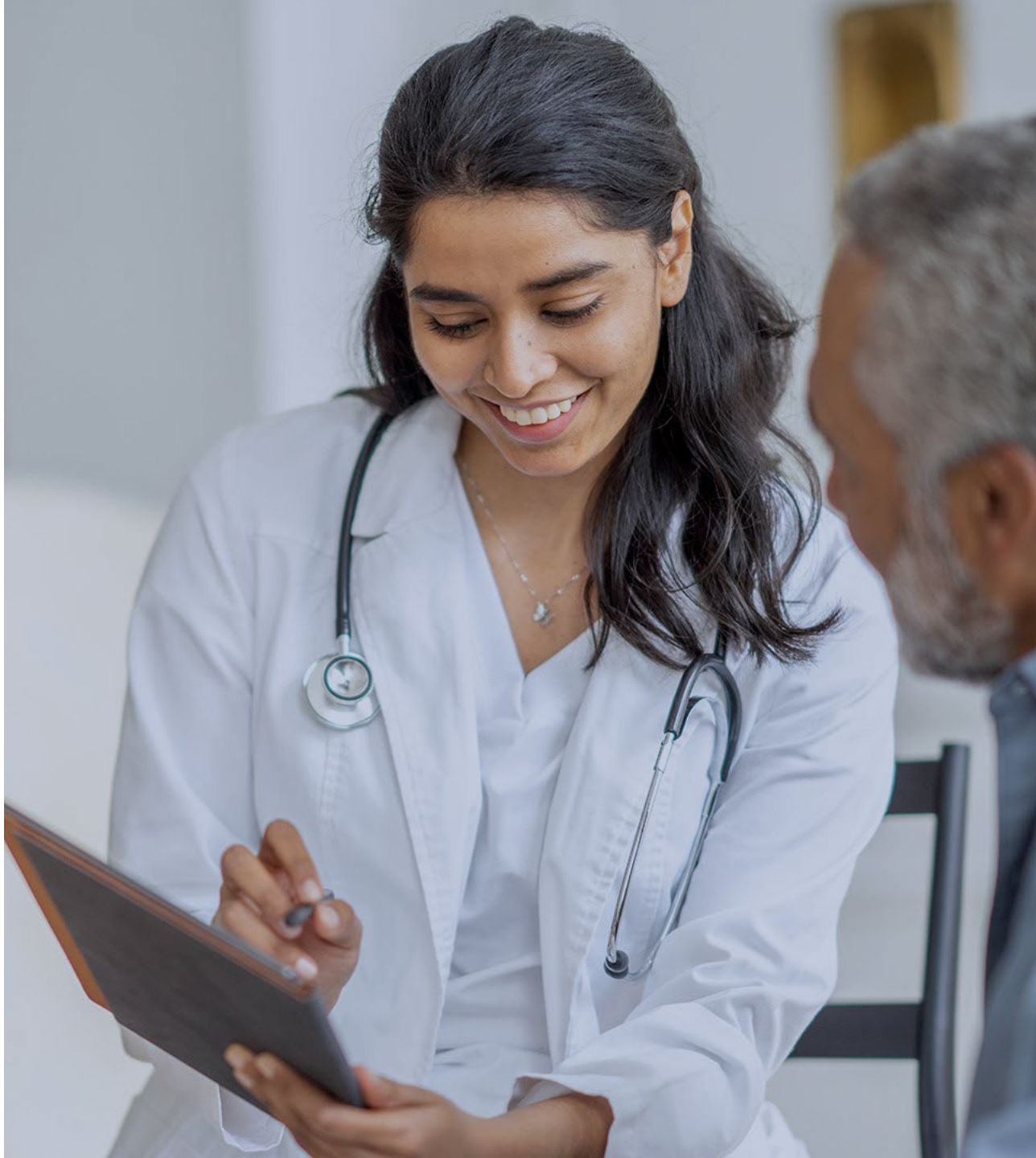
- FL 47 – Total Charges
  - Not applicable for electronic billers
  - Sum of charges for each revenue code on claim
    - Place total of all charges next to revenue code 0001
  - Tip: If covered day count = 0 but total covered charges > 0, we RTP claim with reason code 31090
- FL 48 – Noncovered Charges
  - Sum of noncovered charges, if any, for each revenue code
    - Place total of all noncovered charges next to revenue code 0001

FLs 67 and 67A to 67Q

- FL 67 – Principal Diagnosis Code (Required)
  - ICD-10-CM code for principal diagnosis
  - Also known as primary diagnosis code
    - Condition established after study to be chiefly responsible for this admission, even if another diagnosis may be more severe
- FLs 67A to 67Q – Other Diagnosis Codes (Situational)
  - ICD-10-CM codes for up to eight more conditions if they
    - Coexist at time of admission or developed subsequently
    - Had effect upon treatment or LOS
    - Do not duplicate principal diagnosis
- Reference:
  - CMS ICD-10

FL 69 – Admitting Diagnosis (Required)

- ICD-10-CM code for admitting diagnosis
- Condition identified by physician at admission requiring hospitalization



FL 74 and FLs 74A Through 74E – Procedures/Dates (Situational)

- FL 74
  - ICD-10-PCS Principal Procedure Code/Date
    - Required when procedure was performed
- FLs 74A-74E
  - Other ICD-10-PCS Procedure Codes/Dates
    - Required when additional procedures were performed
- Reference:
  - CMS ICD-10

What You Should Do Now

- Review references and resources
- Share information with staff
- Follow instructions for submitting IP CAH claims
- Develop and implement policies that ensure claims correctly submitted to Medicare
- Attend future education

References and Resources

NGS References and Resources

- ASCA Requirements for Paper Claim Submission
- CBT modules in Medicare University
- Contact Us (NGSConnex, IVR, PCC)
- EDI and How it Works
- *EDI enrollment Process User Guide*
- *Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide*
- FISS Claim Change/Condition Reason Codes
- Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
- Inpatient Admission Prior to Medicare Entitlement Job Aid
- Top Claim Errors
- NGSConnex

CMS References and Resources

- Beneficiary Notices Initiative (BNI)
- CMS-1599-F
- CMS ICD-10
- CMS Fact Sheet About Two-Midnight Rule
- Comprehensive Error Rate Testing (CERT)
- CR8185, CMS Administrators Ruling: Part A to B Rebilling of Denied Hospital Inpatient Claims
- CR8445, Implementing the Part B Inpatient Payment Policies from CMS-1599-F
- CR8666, Implementing the Part B Inpatient Payment Policies from CMS-1599-F

CMS References and Resources (continued 2)

- CR10080, Clarifying Medical Review of Hospital Claims for Part A Payment
- Critical Access Hospitals: Bill Correctly
- Critical Access Hospital Center
- FFS & MA IM
- HETS
- HINNs
- Medicare Fee for Service Recovery Audit Program
- MLN® Booklet: *Information for Critical Access Hospitals*
- MLN® Booklet: *Items and Services Not Covered Under Medicare*

CMS References and Resources (continued 3)

- MLN® Booklet: *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- MLN® Fact Sheet: *Swing Bed Services*
- MLN Matters® *MM13846: Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services*
- MSP Provisions
- Quality Improvement Organizations
- Supplemental Medical Review Contractor
- Targeted Probe and Educate

CMS IOM References

- CMS IOM Publications
  - 100-01, *Medicare General Information, Eligibility and Entitlement Manual*
    - Chapter 3, Section:
      - 10.4, Benefit Period
  - 100-02, *Medicare Benefit Policy Manual*
    - Chapter 3 Sections:
      - 10, Benefit Period
      - 20, Inpatient Benefit Days
    - Chapter 6, Sections
      - 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
      - 10.2, Other Circumstances in Which Payment Cannot Be Made Under Part A
      - 10.3, Hospital Inpatient Services Paid Only Under Part B
    - Chapter 15, Section
      - 250, Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

CMS IOM References (continued 2)

- 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Sections:
    - 50.2.1, Frequency of Billing
    - 70, Time Limitations for Filing Part A and Part B Claims
    - 90, Patient Is a Member of a MA Organization for Only a Portion of the Billing Period
  - Chapter 3, Sections:
    - 10.4, Payment of Nonphysician Services for Inpatients
    - 10.5, Hospital Inpatient Bundling
    - 30, Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)
    - 40.2.1, Noncovered Admission Followed by a Covered Level of Care
    - 40.2.2, Charges to Beneficiaries for Part A Services
    - 50.2, Claim Change Reason Codes
    - 140, Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
    - 190, Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
    - 200.2, Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

CMS IOM References (continued 3)

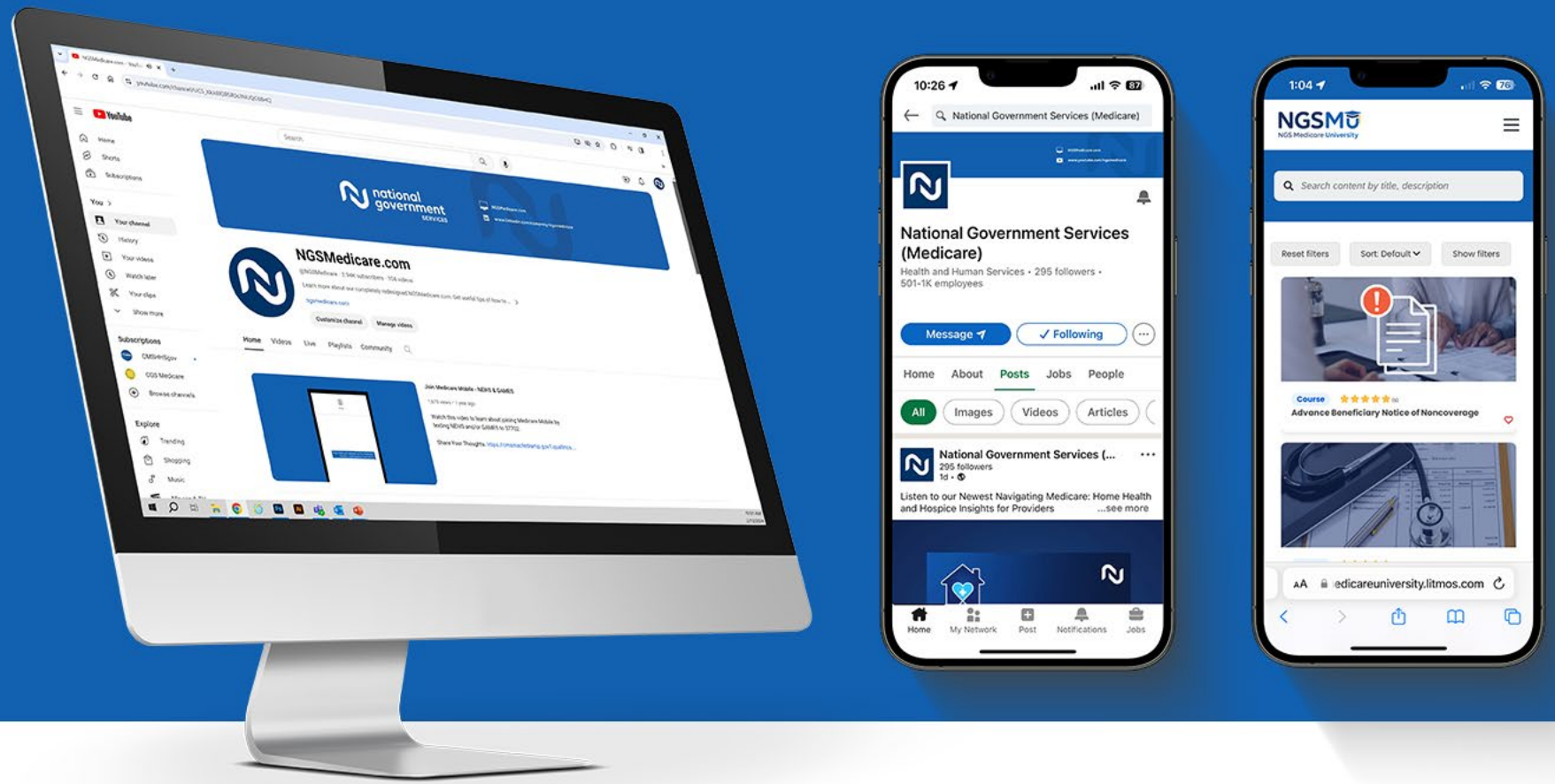
- Chapter 4, Sections:
  - 240.1, Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
  - 240.2, Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made Under Part A
  - 240.6, Submitting Provider-Liable Part A No-Pay Claims
  - 250.3, Payment for Anesthesia in a Critical Access Hospital
- Chapter 18, Section:
  - 10.2.2, Claims Submitted to MACs Using Institutional Formats
- Chapter 25, Section:
  - 75, Billing Code Fields
- 100-16, *Medicare Managed Care Manual*

Additional References and Resources

- 42 CFR, Section 424.13
- 42 CFR 424.15
- 42 CFR 485, Subpart F
- 42 CFR 485.638(a)(4)(iii)
- S1820 of SSA
- *NUBC's UB-04 Data Specifications Manual*

Questions?

Thank you!



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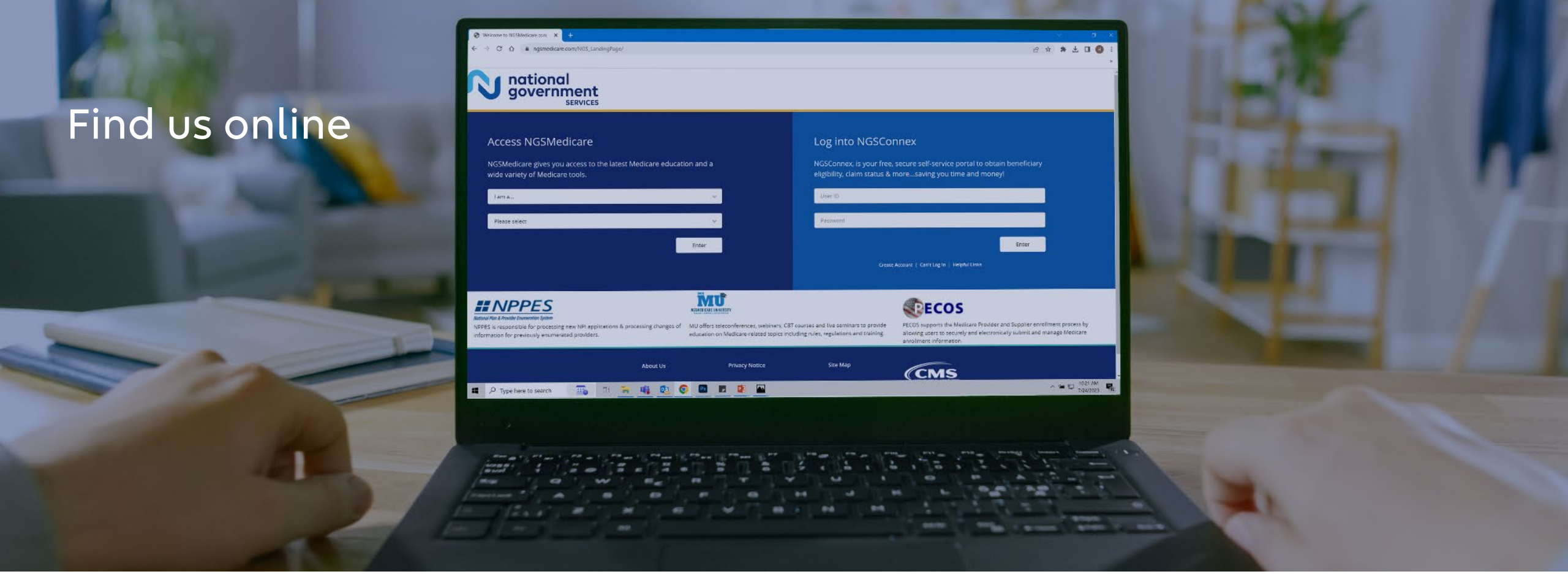

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Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

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